PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$ 0	$[736] (Part A deductible)
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	$ 0	Up to $[92] a day
101st day and after:	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	$ 0	Up to $[92] a day
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
PARTS A & B			
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	Up to $[92] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	Up to $[92] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN D

MEDICARE (PARTS A & B) - CONTINUED

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	PARTS A & B (cont'd.)		
HOME HEALTH CARE - (cont'd)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$ 0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$ 0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$ 0
61st thru 90th day	All but $[191] a day	$[191] a day	$ 0
91st day and after;			
- While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare eligible expenses	$ 0
- Beyond the additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER BENEFIT PERIOD

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	All costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE**			
Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$ 0	$120	$ 0
Additional charges	$ 0	$ 0	All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	Up to $[92] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$ 0
61st thru 90th day	All but $[191] a day	$[191] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$ 0
- Once lifetime reserve days are used:			
Additional 365 days	$ 0	100% of Medicare eligible expenses	$ 0
Beyond the additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B deductible)	$ 0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	Up to $[92] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	80%	20%
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN G

MEDICARE (PARTS A & B) - CONTINUED

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont'd)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$ 0	Up to the number of Medicare-Approved visits not to exceed 7 each week	
- Calendar year maximum	$ 0	$1,600	

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	Up to $[92] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN H

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$ 0	$ 0	$250
Next $2,500 each calendar year	$ 0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$ 0	$ 0	All costs

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	Up to $[92] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN I

MEDICARE (PARTS A & B) - CONTINUED

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont'd)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$ 0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$ 0	$1,600	

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN I

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$ 0	$ 0	$250
Next $2,500 each calendar year	$ 0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$ 0	$ 0	All costs

PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[736]	$[736] (Part A deductible)	$ 0
61st thru 90th day	All but $[184] a day	$[184] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[368] a day	$[368] a day	$ 0
- Once lifetime reserve days are used:			
- Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
- Beyond the Additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[92] a day	Up to $[92] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

MEDICARE (PARTS A & B) - CONTINUED

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont'd)			
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$ 0	Up to the number of Medicare-Approved visits not to exceed 7 each week	
- Calendar year maximum	$ 0	$1,600	

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN J

OTHER BENEFITS (cont'd.)

EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$ 0	$ 0	$250
Next $6,000 each calendar year	$ 0	50% - $3,000 calendar year maximum benefit	50%
Over $2,500 each calendar year	$ 0	$ 0	All costs
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$ 0	$120	$0
Additional charges	$ 0	$ 0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[764]	$[764] (Part A deductible)	$ 0
61st thru 90th day	All but $[191] a day	$[191] a day	$ 0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382] a day	$[382] a day	$ 0
- Once lifetime reserve days are used:			
Additional 365 days	$ 0	100% of Medicare eligible expenses	$ 0
Beyond the additional 365 days	$ 0	$ 0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $[95.50] a day	Up to $[95.50] a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$ 0	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B deductible)	$ 0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$ 0
Part B Excess Charges (Above Medicare-Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All costs	$ 0
Next $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
- Durable medical equipment			
First $100 of Medicare-Approved Amounts*	$ 0	$100 (Part B deductible)	$ 0
Remainder of Medicare-Approved Amounts	80%	20%	$ 0

PLAN J or HIGH DEDUCTIBLE PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE (cont'd)			
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual charges to $40 a visit	
- Number of visits covered (Must be received within 8 weeks of last Medicare-Approved visit)	$ 0	Up to the number of Medicare-Approved visits, not to exeed 7 each week	
- Calendar year maximum	$ 0	$1,600	
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$ 0	$ 0	$250
Next $6,000 each calendar year	$ 0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$ 0	$ 0	All costs

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,** YOU PAY
*****PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $150 each calendar year	$ 0	$120	$ 0
Additional charges	$ 0	$ 0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.